Georgia Department of Community Health

STATE HEALTH BENEFIT PLAN (SHBP)
NON-TOBACCO USERS AFFIDAVIT FORM

Policyholder/Plan Member Name:_____

Social Security Number:_____

Health Plan Options: (mark one) **CIGNA OAP, CIGNA HDHP, CIGNA HMO, CIGNA HRA, UHC OAP, UHC HDHP, UHC HMO, UHC HRA**

□ I hereby certify that all covered members have not used any tobacco products within the past 12 months
□ I have completed a health risk assessment program with the above health plan
□ I have downloaded and read wellness information in an area that is of interest to me
□ I understand that as a State Health Benefit Plan member I have the responsibility to read the current Decision Guide and the Summary Plan Description of my chosen health benefit option
□ I understand it is my responsibility to access the open enrollment Web site each year to make elections and answer the surcharge questions to prevent default surcharges

I also understand that this document must be completed, all boxes checked and returned to my payroll location benefit coordinator in order for the removal of the tobacco surcharge. The effective date of the change will be dependent upon the payroll schedule for my employer. No refund in premium(s) will be made for any previous deductions that included the surcharge amounts. The Internal Revenue Service rules require all premium charges to be prospective.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, and I may lose health coverage for one year, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature_____ **Date** _____

Note: Once you have read and signed this affidavit you must submit it to your payroll location benefit coordinator to have the required deduction information completed. If this form is received without a signature and all boxes checked, it will be returned to your payroll location and will delay processing.

Department/School System Use Only		
Payroll Location #	**Date of first deduction**	**Deduction Amount**